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NOTES ON

Some Forms of Mental Disease.

By T. DUNCAN GREENLEES, M.D., F.R.S.E.

Being Extracts from a Paper read before the Eastern Province Branch, B.M.A., at Grahamstown, on 17th May, 1907.

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Insanity is, as you are well aware, a protean condition, illustrating all the various types and stages of mental disease. To define "insanity" is to attempt the impossible; mental health merges so gradually into mental ill-health that no one can say where sanity ends and insanity begins. The "border-land" is a very narrow strip of mental territory, and is frequently submerged by the waves of mental aberration.

The mind of man is wondrous strange; we know so little of its manifestations in health, and still less do we know of them in disease, so that any classification of its abnormalities must be considered as provisional.

It is rare indeed for the sane mind to be in the same state for long at a time; much less does the insane mind remain stationary, so that we sometimes certify cases as suffering from mania when their real condition is that of melancholia; and conversely, often melancholic cases are maniacal, and are at first considered as suffering from the latter condition.

To be able to diagnose any case of insanity satisfactorily it is necessary that we should first know the normal state of our patient's mental faculties; it is when we contrast his condition *then* with his condi-

tion *now* that we recognise the nature and extent of the defection; further, the environment of our cases, as well as social, racial, and other influences, must be taken into consideration before an opinion can be arrived at. The scion of a noble race trundling a wheel-barrow down Whitechapel, or a Kafir trekking along Piccadilly with nothing on but his blanket to hide his nakedness, while normal conduct in other people, and in other places, and under other circumstances, would be considered as quite abnormal in the instances quoted; and to eat locusts and snakes may be looked upon as an excellent diet for savages, but for a civilised man to dine off such a menu would undoubtedly brand him as eccentric, if not actually insane.

"Madness," or the "*furiosus*" of the ancients is practically unknown in our modern Asylums. Acute delirious mania, fortunately a rare condition, is the only form of insanity which at all resembles "madness," as this term is understood by the layman. Some authorities hold that the type of insanity is changing; no doubt changes in our methods of living exercise a modifying influence on the symptoms of mental disease.

The mind may be exalted, depressed, obliterated, or undeveloped, and under these four conditions we find many grades or sub-divisions, depending upon psychological, ætiological, or pathological factors; and upon these four conditions of mind the various classifications of insanity, as depend upon symptoms, are founded. The name given to any disease may originate in various ways, and thus "confusion is doubly confounded." For example, we have Graves's Disease, named after its discoverer; again we have puerperal insanity, referring to its cause; mania and melancholia, illustrative of the chief symptoms; cirrhotic kidney, referring to the pathology, and, finally, we have diseases named owing to their termination.

Custom and usage gives the classification I adopt in this paper the pre-eminence it possesses; I fear it has nothing else to support it, and we are still searching for a better classification.

We shall first consider *States of Mental Exaltation*, (Psychlampsia, as Clouston calls it) or, as it is more commonly termed, *Mania*. A state of mental exalta-

tion may exist in persons of sanguine temperament, but in most of these cases there is usually some defective will-power, and the individual usually has reactionary periods when there is some mental depression.

As regards degrees of intensity we may have acute, sub-acute, or chronic mania; as regards ætiology we may have puerperal mania, or dipsomania; as regards recurrence we have recurrent mania; and as regards the age at which the disease may appear we have adolescent, climacteric, and senile manias.

The first case I show is that of a boy, A. B., aged 18, who is now convalescent from Adolescent Mania, accompanied by masturbation—a symptom often the result, rather than the cause, of the mental state. His illness began by depression, and avoidance of his sisters; then he became restless, excited, boastful, violent, and assaulted his mother and father.

On admission he was flighty, boastful, off-handed and casual, untidy in dress, had an exalted "devil-may-care" manner, and kept calling out for cigarettes and women.

In such a case the risks are to dementia, and all the more if there is some original mental instability, such as hereditary brain weakness.

The writings of the insane are often of extreme interest, and give an insight to the morbid mind that we might not otherwise experience. We have the jerky, shaky writing of the general paralytic, frequently missing words or letters; we have the flourish of the patient suffering from delusions of grandeur; we have the frequent under-linings of the chronic maniac, and we get, when he does write at all, the incoherent scrawl of the dement.

This boy writes his parents very frequently, and his letters reveal a happy, contented mind, pleased with his surroundings, but with a morbid craving for such things as would amuse a child: "My Dear Parents, I received your welcome letter two days ago. When you come to see me (D.V.) please do not forget a (Goodie Box). N.B.—Please don't forget 'Flag Cigarettes' (1 Box about 9/6 for a box), German Sausages, Cakes, and other dainties such as Chocolate, etc. As regards health, I am feeling stronger than ever I did in my life——Hoping to see the 'Dear Old

Folks at Home' *once* more, I remain, Your loving son."

Sometimes these cases become quite poetical, but there is often a certain amount of thinly veiled obscenity in their effusions, and a marked tendency to underlining, where such is not necessary.

When a mental disease, originally acute, lasts for two years it is customary calling it "Chronic." To designate a disease *chronic* suggests incurability, but this is not necessarily so in mental diseases, and the term is only applied provisionally, and for convenience of classification.

The case illustrating this condition is a man, C.D., now aged 60 years; he was here before, some 13 years ago, but got well and was discharged. I often think that the return of a mental attack must make things look very gloomy to the patient, and diminish his hopes of ever keeping well. This case, although he has been here now for five years, has shown no signs of improvement; he is continually shouting incoherently; he is very abusive, threatens violence, and lately his memory has failed, and he mistakes the identity of persons he formerly knew quite well—all symptoms indicating the approach of dementia.

Such a case presents little of interest; it is because it is a common one that I show him. These cases—Chronic mania and Secondary dementia—form the bulk of an ordinary Asylum population, and for such the drastic treatment, recommended by Rintoul, might well be adopted.

The influence of alcohol on the brain and mind is of peculiar interest to all concerned in the study of mental disease; the results of alcoholism would appear to depend on the original character of the patient, in the same way as drunkenness may make one man dull, heavy, and depressed, and another jovial, boisterous, and excited. Illustrating these two conditions, I exhibit two cases, admitted about the same time; both have been inveterate drinkers, and both have had repeated attacks of alcoholic delirium, and yet their mental symptoms now are exactly opposite—the one being restless, excitable, having hallucinations of both sight and hearing, and the other dull, depressed, sluggish in ideation, already tending towards dementia.

As in most cases of mental disease the prognosis in alcoholic insanity very much depends upon the history of the case, and whether hereditary influences exist.

It is most interesting watching the effects of this poison on that delicate organism, the brain; we get degenerative changes within the cells, we have an increase of the neuroglial structures, and finally we get alterations in the capillaries, so that their walls are thickened, and the cells are deprived of their nourishment. As these pathological changes progress we can trace their influence on the character of the patient, and in his habits. The honest man becomes dishonest and deceptive, the truthful one becomes addicted to lying; the downward progress of all the intellectual and moral faculties becomes evident; this degenerative change begins with the higher and last developed functions, and ends with the lower or organic, so that, at the last, profound dementia terminates the mental history.

When we find cases whose main features is the expression of delusions, without a concomitant or material influence on the habits or conduct, we usually apply the term "delusional insanity" to such, and it is sometimes convenient to call a case "mania" where the delusions are of an exalted type, as we should term one "melancholia" when they are depressing in character.

That even a "sane" person may have delusions is well known, but so long as these do not influence his conduct he need not be sent to an Asylum. For example, we have "Jesus Christ" here, as well as several kings, but these persons work very well, and do not, now at all events, show that they differ from other people, except when they are induced to speak of their delusions. They are now here because at some time, possibly, their delusions gave character to their conduct, and a king roaming at large might very easily be a source of danger to the public or himself.

The following two cases of "delusional insanity" demonstrate these facts; they are "full" of delusions, and yet they are quiet, well-behaved, and excellent workers.

The first case is that of a man E. F., aged 51, whose intellectual faculties all appear intact, but he has a woman who visits him every night, and annoys him

very much; there are spirits that haunt his weary couch during the still hours of the night, and sleep is destroyed because persons electrify him. At times he is simply amused at these psychic experiences; at other times he is somewhat depressed at the fact he cannot get his rest with these disturbances.

The other case is that of a lady G. H., aged 40, single, who for two years before admission had been eccentric, and took to wandering about the veld alone. Her delusion is that she is being persecuted by her sister-in-law, who presses on her stomach, although she is some 300 miles away, and puts evil thoughts in her mind; she likewise thinks a black woman tears at her side. These mental experiences make her at times noisy at night, but she is never violent or excited, and, as a matter of fact, she has lately taught a number of imbecile children we have here, taking a keen and intelligent interest in her work. She wrote her brother the other day, showing how utterly "mixed" she is, and how much her delusions appear to influence her thoughts:—

"My dear brother, I am writing to say that the woman whom you have in your home is damned. Burn her with vitriol because you may not bury her. She devils such a big lot that she uses the food up from the baby (if she is in the family way). . . . . She is not to be trusted, and if she boweled for me to deceive you that I want to stay there, don't believe her. Boweling, which you call spiriting, is a devil's craft; she does the deceptions. . . . . she shakes my bowels and inside about that the food is shaken; then I think she gets through the water to the child too."

The nature of the delusions in this case point to, or suggest, some organic disease—as a basis, as it were, for the delusions. I have seen a case of "rats knawing at the stomach" turn out to be gastric cancer, and delusions of unseen agency, such as mesmerism or electricity, working on a patient during the quiet watches of the night, are very characteristic of heart disease—especially when it affects the aorta, or its valves.

The following case very well illustrates the condition we term *"Recurrent Mania"*: I. J., a Colonial woman, aged 32 when she was admitted in 1899—this being her fifth attack. There is a bad family

history—her father having committed suicide, her mother being eccentric, she had a brother in another Asylum, her sister has been twice insane, her paternal uncle is an inmate here, and he, having married his cousin, had two imbecile boys! On the other hand, my patient has two cousins distinguished in the legal profession, and she herself is, when well, about as keen and intelligent a woman as one will meet anywhere. We here have an excellent illustration of the well-known axiom that genius is closely allied to insanity. On admission she was very restless, emotional, foul-tongued, abusive, destructive, and violent, and she continued in this condition for about two months when she settled down—without any intervening fit of depression, as we sometimes find in "circular insanity"—and kept fairly well for about a year, when she had an ephemeral attack, which, however, aborted, but for some time she certainly was on the border-land of a relapse. In April and May of 1901 she was again excited, the attack lasting several months, when she again became well, only to relapse in the following December. In the succeeding June, she had a slight attack, and in the following April she had an abortive attack. Christmas of 1904 saw her again excited, also the following March, and again in November. In January, 1906, she was again excited, settling down after three months' illness, and since then, and until last month (April) she kept well. She is now going through her 15th known attack of mental excitement, and she is not yet in her 40th year—a sad record in a short life. Latterly, in her attacks, she has been kept in bed, and her weight has gone down from 130 to 97 lbs. in one illness. During these mental explosions she is restless, excited, emotional, impulsive, falls in love with the Medical Staff, believes she is in the family way, and has latterly exhibited many of the clinical features of the condition known as "Old-maids' Insanity," the classic description of which is so well told in Clouston's work. She writes long effusions to the Medical Officers, addressing them by endearing terms, and usually ascribing her supposed enlarged condition to their influences.

Such repeated mental explosions, with barely time to recuperate, must wear out the delicate gearing of the mind; and, as a result, we may in time find, after

a specially severe attack, some blunting of the intellectual faculties, some dulling of the higher mental processes, indicating the downward progress to dementia.

If Mania is regarded as a disorder of the cortical strata that are lower, and first developed, then we may consider "*Melancholia*" as being due to a disorder of the strata which are highest and last developed. This theory of Hughlings-Jackson helps us materially in explaining many of the lesions of the mind, and is proved, to my mind, by the fact that while mania is common among savages, and even the lower animals, melancholia is rare, and is, in fact, a disease of more fully developed organisms.

States of Melancholia (Psychalgia, Clouston calls them) occur, like Mania, in degrees of intensity, and arise from various causes.

The buoyancy of well-being has its counter-part in simple ill-being, amounting, when intense, to actual mental pain. While many men may be depressed from a "liver attack," some become depressed at the loss of friends, or money; and others may become melancholic without any appreciable cause whatever, or without sufficient cause. It is these latter that we consider insane, that is when the result is out of all proportion to the cause. In health the cerebral functions react in obedience to certain conditions of the body, or the mind; when this reaction is out of proportion to the originatng cause, then we recognise the condition as no longer physiological but pathological.

As an example of Acute Melancholia the following case may be shown: K. L., aged 47, admitted 19th October, 1905; this is his first attack; the "statement" says his mother died of "broken heart—a condition not recognised in our text-books, but well known in life. The ascribed cause of his mental breakdown was business worries. His illness began by sleeplessness, brooding over his losses, going off his food, and finally the crisis suddenly came by his jumping off the roof of his house, with intent to commit suicide.

On admission he was depressed and miserable, wringing his hands; he answered questions only in monosyllables, and informed me he had committed some crime, that his soul was lost, and that he had denied Christ. No organic disease was detected, but

his tongue was foul, and he suffered from constipation.

His condition since admission has shown little change; at times he seems a little better, but no definite progress can be recorded. His letters to his wife —and he only writes under great pressure—are short, abrupt, and always refer to the utter hopelessness of his position both here, and hereafter, and he expresses a desire for it all to end.

His intellectual faculties are still keen, and, when he had to do so, he wrote several smart business letters to his wife.

Look at him now; observe how he stands, with head down, moving his hands over each other as if washing them, a very picture of mental pain and misery. When questioned he gasps, and then jerks out, in a whisper, a monosyllabic reply, but he will not carry on a conversation, and it is only with great difficulty he can be induced to employ or amuse himself.

This case is an interesting one, although typical of many we get in our Asylums.

(1). The probable cause—as the predisposing factor—in this case is the onset of the climacteric, for, from the age of 45 to 60 in men, as well as in women, certain physiological changes, accompanied frequently by psychological alterations, occur—not, it is true, to so marked an extent as in women, but still the passage of robust manhood to old age is broken by an interlude, as it were, during which, even in health, important changes occur in the organism; this period is called the "climacteric," and during this time men, as well as women, are peculiarly liable to mental break-down, especially if there is some predisposition to insanity. And it is interesting to note that "Climacteric Insanity" is more likely to be accompanied by states of depression, with suicidal proclivities, than maniacal conditions.

(2). I show this case as an example of Acute Melancholia, although he has been insane now for 18 months, because his symptoms cannot yet be considered "chronic," and so long as his intellectual faculties remain intact the prospects of ultimate recovery are still existent, and therefore we cannot call him chronic.

(3). I would direct special attention to the condition of the alimentary canal in this case. We know the ancients ascribed all melancholia to black bile circulating in the blood, and while a sluggish state of the bowels may induce depression of spirits, there is no doubt that melancholia induces a sluggish state both of the liver and bowels.

The modern idea of these cases is that the mental state is due to an accumulation in the system of some toxin, manufactured in the organism, and the result of metabolism of the tissues, together with failure of the eliminatory apparatus; that the condition is, in fact, one of the forms of auto-intoxication.

When the melancholic condition remains stationary, or at all events shows little disposition to pass into the next and lower mental stage, *viz.*, Dementia, and no improvement takes place, we give it the name *Chronic Melancholia,* and this next case illustrates this condition.

M. N., aged 39, admitted 14th June, 1901; his illness was ascribed to drink; there is no family history admitted to any of the neuroses, but his mother is a rather eccentric woman. Before admission he had mutilated himself. He was depressed, mumbled to himself when questioned, but no delusions were elicited. Later he thought the world was coming to an end, and that people were attempting to poison him. He will stand for hours in the same position, and on the same spot, without moving or speaking, and lately the indications of approaching dementia are becoming more evident. Such a case is very hopeless as regards the prognosis; he has never once attempted to throw off the depressing ideas with which he is obsessed; his mind will become more and more enfeebled, until the darkness of mental death over-shadows him, and he is relegated to the hopeless class of "secondary dements."

Closely allied to melancholia, especially the stuporose type, and occupying a position mid-way between this condition and dementia, we find a "group of symptoms" to which Kraepelin has given the name *"Dementia Praecox,"* where there is a tendency, *ab initio*, to early dementia. This is one of the insanities occurring at puberty, or adolescence, in boys or girls

of neurotic parentage, and the earliest symptoms are general apathy and loss of interest; the patient becomes indifferent to things and persons that formerly interested him; he neglects his personal appearance, attention is early impaired, and the reasoning powers are defective, although memory may not, in the early stages at all events, be affected. Delusions and hallucinations may be present, but they do not materially influence the character or conduct, and they generally disappear, or at least become less prominent in the later stages of the disease.

The prognosis is bad, and the treatment, if the case is met with early enough, is the removal of the patient from his home, the correction of bad habits—they are often masturbators—the treatment of symptoms as they arise, and the improvement of the general health.

The case I show illustrates this condition very well: O. P., aged 21; there is a well marked neurotic family history on both the mother's and father's side. This girl was studying as a teacher, she had a severe attack of dysentery; then she became sleepless, restless, took to wandering about alone, and finally made a violent attack on her parents. She is pale, anæmic, and is said to suffer from occasional attacks of menorrhagia. She will not speak, sits with her head hanging down, and her bodily health has not been very good; she has had threatenings of tubercle in one of her lungs, and she often suffers from eczema of the face and ears. Her mental condition shows no signs of improvement; it is rare that she occupies herself, sits all day as you see her, with her chin resting on her breast, answering questions only in monosyllables, or not at all. It is clear, however, she knows everything that is taking place around her, and she occasionally has sudden violent paroxysms, attacking the patients or Nurses who may be near her.

The prognosis of such a case is necessarily unsatisfactory; if she does not develop some acute disease, such as phthisis, which will carry her off, she will drift slowly but surely into secondary dementia, and become a chronic inmate of the Asylum. Even then she will be liable always to violent paroxysms of excitement—showing that the dementia is not complete, or so profound as it is after other acute mental diseases.

The mental state called "*Stupor*" is most interesting,

for it may present the symptoms of katatonia, catalepsy, or hypnotism. In stupor there is a suspension, rather than an abolition, of the emotional, intellectual, and volitional operations, such as is found in terminal dementia, and this fact would seem to indicate that this condition, stupor, is, as it were, the half-way house between melancholia and dementia. In a state of stupor the patient may correctly apprehend external things, he may know all that is going on around him, and hear all that is being said, but he is in no way influenced by them, although sometimes, after recovery, a vivid recollection is experienced of everything that happened during the stuporose period. Stuporose patients often exhibit cataleptic symptoms. The condition is rather a rare one in Asylums, and the case I show is one exhibiting many interesting symptoms.

R. S., a female, aged 29; the cause of her mental illness was "fever," and a love affair, in which she had been badly treated by a man who was already married, and he did not inform her of this fact. Both were Sunday-school teachers, and he used to see her home frequently. At first she refused to speak, eat, or dress herself, took to her bed, and would not get up.

On admission she had a peculiar strained expression; she answered questions slowly, and only after long intervals, as if her powers of comprehension were limited; her memory was defective, she was in poor bodily health, and slight organic pulmonary change was noted in her right apex.

For a time she talked fairly readily, but slept and took her food badly; then she passed into a "dazed" condition, eyes staring, and with an expression of intense fright; she would sit for hours without movement, and when any of her limbs were moved she resisted powerfully—the muscles passing into a rigid condition. When this resistance was overcome by force, and the limb placed in position, it remained thus for some time, and then was allowed to gradually lapse into a more easy position. These are symptoms characteristic of the condition known as Katatonia (Kaulbaum).

All the time she is being experimented upon, her eyes remain either closed, or else open, but with a "far away" look in them; questions do not appear to

affect her, nor does she appear conscious of her surroundings.

For a few moments at a time she sometimes apparently wakened up, her expression became more intelligent, and she would even answer a question or so, but these lapses of intelligence did not last long, and she soon passes into her usual stuporose condition.

While apparently unconscious, it is clear by her conduct, when not observed, that there is some intelligence existent; thus she will gradually move her position on her seat nearer and nearer to another patient, and then deliberately pinch or strike her, or else will suddenly take a fit of smashing crockery. Several times, when moving away from her, she has suddenly put out her foot with the object of tripping me up. She has become dirty and neglectful of her habits lately.

I have attempted to influence her emotional faculties by speaking to her of her old parents, and her home, and have succeeded in getting the tears to come, and she weeps quietly.

The treatment consists in plenty of nourishing diet, cod-liver oil, the battery to her head and neck, and lately she has been kept in bed while undergoing a course of Tabloid Thyroid Extract treatment. She has had several reactions—increased temperature and pulse, but with no benefit so far; she has several times fainted.

This, then, is her condition at present. What are her prospects of recovery? She may just as suddenly recover as she became stuporose, or she may pass gradually into terminal dementia. There are really no means known to arouse such cases from their lethargy, and it is sad seeing them drift into hopeless dementia. There is a want of tone in the whole system, food does not appear to have much nourishing effect, metabolic changes are diminished, and wasting diseases, such as phthisis, are very liable to end the history, even before the onset of chronic insanity.

The next form of mental disease to which I direct your attention is that associated with *Epilepsy*. While epilepsy may not, of itself, be insanity, the two conditions are very closely associated together, as to cause and effect; and in every epileptic the mind gradually, in time, becomes affected, at first only temporary—

before, in place of, or after, a fit—but later, if the epilepsy is not cured, the mental disease becomes permanent.

The cortical cell explosions, which constitute a fit, affect the delicate structure of the cells concerned in the higher mental processes; a continuation of these explosions produces pathological changes, and morbid mental manifestations result.

I will be informed that each of you knows cases of epilepsy whom it would be unkind, and untrue, to say they were insane; but I would point out that, in every case, it will be found there is some mental change, and enquiry will elicit the fact that this change, as time passes, is becoming more and more marked, so that it is impossible saying whether your problematical case is in the border-land of insanity, or whether he has actually passed over. No epileptic is *always* perfectly well mentally, and this may be taken as an axiom in mental medicine.

It is possible we only get the worst class of epileptics in our Asylums; we know nothing, *until afterwards,* of the awful tragedies that occur outside, often caused by epileptics.

The example of this disease which I submit, is a young man, T. U., well educated, and formerly a school teacher in the Western Province. He was admitted in 1894, but shortly afterwards his parents took him out against my wishes. He was readmitted in 1896 after nearly murdering his father. At times he is quiet, but frequently he becomes extremely excited, violent, and attacking persons about him, thinking they are devils, etc. Like most epileptics his ideas readily take on a religious bent; this is especially observed in his letters, which look more like apostolic epistles than ordinary communications, to his parents. They are generally full of biblical quotations, and he usually ends them by the benediction.

He is steadily getting worse mentally; the lucid intervals are getting shorter in duration, and less frequent, and his intellectual faculties are slowly becoming more and more blunted.

The end of such a case is "epileptic dementia," if death does not interrupt the progress of the disease. Operative interference, in *idiopathic* epilepsy, is worse than useless, and sometimes results in more severe

and more frequent seizures. We have not yet localised epilepsy in the brain, and to remove a small piece of the skull, presumably to relieve pressure, where none exists, and where the disease may be distributed over some millions of cells, scattered throughout most of the cortical surface, is a procedure as illogical as it is unscientific.

In this case the epilepsy came on *after* the full development of the intellectual faculties. Epilepsy may occur at any period of life, but the most frequent periods for it to appear are in childhood, and at puberty. In the former case we have a condition which may be termed "*epileptic imbecility,*" which, as you may understand, varies very much in degree, according to the time of onset, as well as the frequency and severity of the fits.

The following case illustrates what may be called a higher type of epileptic imbecility:—

V. W., a young girl, was admitted in 1901, said to have suffered from epilepsy since she was a child, but the fits were not severe enough to prevent her attending school, although her education was necessarily much interrupted, and is now rather defective. She steadily became worse mentally, until she became quite unmanageable at home, and she had to be sent here. It is noted that such cases are never sent for special treatment until some crisis takes place, or until the relatives are compelled, for the safety of themselves and the public, to send them to an Asylum.

Since admission she has taken fits fairly frequently, that is perhaps an average of one every day, and she is liable to frequent outbursts of maniacal excitement —we call it epileptic furor—for which seclusion in a darkened room for a few hours is the most efficacious treatment. A more plausible and deceptive girl never existed; she once tried to strangle herself simply to get a Nurse into trouble, and she is always threatening to cut her throat if she does not get her own way. She is often in "hot water" with the other patients, and, without fear of consequence, will attack the most powerful woman in the Asylum. And yet she writes the most beautiful letters home—telling them all of the state of the weather, the condition of the crops, and how much she enjoyed her last dance!

Her epileptic seizures are peculiar—the aura is a most piercing shriek, then she pierrotes like a top spinning for a few moments before she falls down. As is usual with most epileptics, she makes unfounded charges against the Staff, that they beat her while in a fit, etc.

With regard to the treatment of epilepsy my ideas have undergone some change since I first entered upon the specialty of insanity 23 years ago. I was taught that no medical man was justified in sending an epileptic to an Asylum until the bromides had been given an extended trial, and that the only cure for idiopathic epilepsy was to be found in their free administration. With the unfortunate experience of several deaths, and a case of utter physical paralysis, which I ascribe to this "prolonged bromide treatment," I have, within late years, practically abandoned this treatment, and I dare say my results are as good as those who give this drug in large doses of from 75 grs. to 90 grs. daily.

I believe the epileptic seizure to be due to a cellular explosion, which occurs when the cortical cells are fully charged, and the fit is simply Nature's method for relieving the great tension within the cell. That "Bromides" do good for a time suggests that they merely "bottle up," as it were, this energy; and, in these cases, the fit, when it does occur, is much more severe, and the risks of passing into "status epilepticus" greater.

The more scientific treatment, to my mind, is to direct our attention to the prevention of an accumulation of this explosive material within the cells; this is probably caused by an excess of the results of metabolism retained within the blood—a species of auto-intoxication, in fact. The treatment I adopt is a careful attention to the hygiene of the alimentary tract, regular action of the eliminatory apparatus by the frequent administration of salient aperients, easily digested foods, with plenty of vegetables, and a sparing meat diet. As a result of this my epileptics are quieter and not so quarrelsome as they were, and I believe the fits are diminished in number and severity.

General Paralysis.—Clouston calls this a "true disease," a pathological entity—in contradistinction to

the other forms of insanity, which, so far as we know at present, are merely functional disturbances, without any organic lesions.

You are aware that three stages represent the course of general paralysis—a stage of excitement with exaltation, a stage of quiescence, with steady paralytic progress, and finally, a stage of trophic lesions, bed-sores, total paralysis, and death.

At the present moment there are no cases illustrating the third stage in the Institution, and it is rare indeed that we get any in the very earliest stage; the two cases shown are examples of the end of the first, and the second stages of this interesting disease.

X. Y., aged 33, was admitted in March of last year; he is said to have had had sun-stroke three years previously. His mental breakdown began by a fit of depression and moroseness; this is a very common method for general paralysis to first assert itself. Then he suddenly became violent, excited, and spent £50 in one afternoon. For a poor farmer this amount was excessive, and he simply wasted it in the purchase of useless articles. On admission he was exalted mentally, laughing and shouting, boasting that he owned the whole world. His pupils were equal, and contracted, the knee jerk was absent; his heart quickened, but action regular.

He continued excited, expressing exalted grandiose delusions, thinking himself a multi-millionaire, and that he had bought up the whole of the Railway systems of the Colony.

He gradually settled down, becoming more reticent as to his delusions, but appeared very facile, was easily pleased, and showed an exaggerated, jaunty, polite manner, becoming very untruthful, and took to pilfering trifles that did not belong to him.

At the request of his wife and mother he was handed over to their care, but several months afterwards, viz., in February of this year, he was re-admitted as bad as ever. At home he seemed to have improved for a time; then he got to be easily tired of work, was noticed to be untruthful without any specific reason; sleeplessness and restlessness returned; while staying at an hotel, he one night set fire to the curtains in his bed-room, and made an attack on his wife. All his old boastful delusions then returned, and when he

was brought back here he informed me that he was King of Germany, and had just purchased the whole of Grahamstown for 35 billions!

His conduct was boisterous, his manner and language exalted; he was constantly "on the go"; facial muscles twitching, gait staggery and spastic when he walked.

There is marked ptosis of the right eye—a symptom often noticed in cases of syphilis of the nervous system. He suffers from "gleet," which he confesses to have contracted some years ago. His pupils are equal, much contracted, and do not respond to the light reflex.

He has spent a good deal of his time in the padded room since his return, his condition being such as to render it impracticable his associating with the other patients, and he has destroyed any amount of bedding, besides his own night costumes; everything he can get hold of he tears to ribbons in a few minutes, and generally, for some time at least, he kept things lively. Then he developed synovitis of the knee, the result of a kick from another patient, and after this healed, he had a severe attack of dysenteric diarrhœa, which has considerably reduced his strength, so that now he is in a feeble state, whereas formerly he was a big burly man.

B.A. is an example of the *second stage* of general paralysis; this patient is aged 48—rather old for this disease—was admitted in August of last year; the exciting cause was stated to have been worry and overwork—he is a Civil Servant!

His illness began by his becoming simply stupid at his work, then he became extravagent, developed exalted ideas, and his habits became depraved, and he was addicted to masturbation. On his admission he was reported to be fatuous, silly, and appeared to have a very good opinion of himself. He had delusions about possessing money, but these were not very pronounced.

He became restless, boastful, and masturbated openly; he had several attacks of vomiting. We often find in this disease gastric and other crises such as are found in locomotor ataxy. This patient's condition steadily became worse, so that he was confined to bed. While there he seemed to improve a little, and was

allowed up, when he took to accumulating rubbish, stuffing his pockets with whatever he could pick up. Then he took to his bed again, suffering from a boil on his leg; the nursing in bed, and special diet has again considerably improved his condition; his habits are better, but the physical symptoms are still well marked, and recently he has been offering us important posts in the manufactory he is about to start for the purpose of making a specific for syphilis, the composition of which he retains as a secret!

He will likely remain in this condtion for a few months longer, and then perhaps have a "congestive" seizure, and die from it, or else suddenly break down, become bed-ridden, develop bed-sores, and death will end the scene.

In the female, general paralysis runs a very slow course, and occurs much more rarely than it does among males. Fortunately I have a case under treatment now, illustrating its sluggish progress, and which was correctly diagnosed many years ago.

D.C., a German woman, aged 30, was first admitted here in 1902, and discharged recovered towards the end of that year, to be re-admitted in May, 1903. Further than the fact she had led a loose and immoral life, nothing could be ascertained as to her antecedents. On admission she was facile, agreed with everything said to her; her speech was slow, she clipped some of her words, and the superficial lingual and labial muscles are constantly twitching while she is speaking. The knee jerk is exaggerated, pupils unequal, the right being the larger, and both are insensitive to light. Her intellectual faculties are very much impaired; she doesn't know her own age, and is for the most part incoherent, and is often dirty in habits and demented.

Her gait is peculiar and straggling—she waddles like a duck when she walks. She is fat and lazy, but often takes to her bed for obscure nerve troubles; these attacks are accompanied by flushing of the face and slightly raised temperature.

Such a case may live for years; I have known general paralysis last in the female for 15 years, but the end is the same in either sex, and a fatal termination is all we can look for.

Hitherto we have discovered no specific for this

most fatal of all diseases we are acquainted with in our Asylums. The two theories extant as to its causation are syphilis and germ poisoning—the former theory being advanced by the London School, while the latter theory has been advocated by the Edinburgh School of Neurologists. Dr. Ford Robertson, of Edinburgh, maintains that general paralysis is caused by a bacillus which finds its way into the system by means of the bowel, as well as possibly by the air passages. If this theory is proved there are prospects of a specific for this disease being discovered. Certainly, whether the lesion is syphilitic or not, anti-syphilitic remedies seem to have little or no effect in arresting its course. Nevertheless, in my practice, whenever I have a case where there is the slightest possibility that it may be syphilitic, I invariably put my patent on a long course of Pot. Iod. as well as Mercury.

Secondary, or Terminal Dementia, (Psychoparesis, Clouston calls it) is that condition of the mental processes in which, according to Sir Crichton Browne, the nervous system has been irreparably damaged by acute storms of disease, or where the individual has subsided quietly into the depths of fatuous mental degeneration.

As death is the natural termination of all somatic disease, so dementia is the natural ending of all acute mental diseases, and as any organic lesion leaves its imprint permanently on the organ affected, so all acute mental storms never pass away wthout leaving behind some traces on the delicately constructed nervous matter.

Further, as the province of the general practitioner, in the treatment of somatic disease, is to avert a fatal termination, so it is the duty of the mental physician to use every endeavour to prevent the onset of dementia.

It is almost an axiom with some—"Once insane, always insane," but there is just as much truth in the statement,—"once pneumonic, always pneumonic"; or, as a matter of fact, the same rule might apply to almost any disease. We know that disease tends to recur, and it then exhibits a special affinity for the same organ.

This tendency to "Terminal Dementia" is one we all dread in our acute mental cases. I would much rather see a patient remain for an unlimited time acutely excited, or depressed, than that he should drift into Dementia.

Cases sometimes become demented when such an ending was least expected, but we find that, in these cases, there is generally some pre-existing condition, some instability of the nervous system—perhaps from a hereditary predisposition to the neuroses, that we did not know of, so that our prognosis has to be very guarded until we know the full history.

In its symptoms dementia presents the characteristics that its name implies—an absence of mind, and is distinguished from Imbecility and Idiocy, where there never was a mind, or it never becomes fully developed. In the one there is loss of mind, in the other there never was a mind to lose.

The dement has a vacant expression, there is an utter want of interest in everything that makes life interesting; he sits all day with his head hanging down, will neither voluntarily eat, dress himself, nor even attend to the ordinary calls of nature. All the organic functions are sluggish, the bowels are constipated, the cardiac systole weak, and the circulation feeble; respiration is carried on with as limited an expansion of the chest as is consistent with life, and the higher mental functions are likewise deadened to any stimuli.

Such cases is not likely to live so long as a sane person; nevertheless the quiet untroubled life of an Asylum often enables these patients to out-live their sane relations and friends.

Coulston says we have no reason to think that a brain which has a perfectly sound heredity (and how few brains are thus?) can, by any series of bad conditions, be made to pass into typical dementia, and I fully concur in this statement.

F.E., a female, aged 35, was admitted to this Institution in 1903. She was a widow, and married again by the time she was 21 years old, so that she could not have enjoyed a long girlhood. No hereditary history to insanity was admitted, but it is not only possible, but probable, such exists. Patients' relatives, both here and in England, are always ready to deny a

heredity; it is sunstroke, a fright, a bite, or in fact anything but hereditary mental instability that caused the illness!

About 14 years ago this patient had puerperal fever, after which she never recovered her mental balance. At first she had hallucinations of sight, took an intense dislike to her husband and child, lost her appetite and sleep, became restless and violent, and then rapidly passed into dementia. Puerperal insanity is one of the most recoverable of all the forms of mental disease, and when such a case becomes chronic we generally find that there is some pre-existing mental instability, such as hereditary predisposition to insanity, or some of the neuroses, present. These are interesting cases to nurse, the physical state usually demanding careful nursing, for they often become septic, and the mental symptoms are usually acute and grave, even causing death from exhaustion sometimes, especially when the case has been neglected at home.

The ending of cases of dementia, where the mind is already dead, can only be physical death. Demented patients have no mental pleasure or enjoyment in this life; they help to fill our Asylums with hopeless incurables, and are a burden on all concerned. It is only the great humanitarian principles, characteristic of all civilised nations, that prevent the adoption of some such methods as are now being advocated in several of the American States, with the object of "removing" the incurable, to make room for the curable, insane in our Asylums.

The time is hardly ripe for the advocacy of these methods in our British Asylums, but so sure as night succeeds day so sure will the time come when men will realise the enormous burden they are called upon to bear in the maintenance of the hopelessly sick.

When this fact is fully realised, a new dawn is imminent in the history of our race, and I will make bold to say the plan then adopted will not be an elimination of the chronics from our Asylums, so much as the general adoption of such laws as have for their object the prevention of disease. And, of all the diseases our weak and frail flesh is heir to, insanity stands out pre-eminently, as being perhaps the most preventable, if people would only see it.

Not until, by education and personal experience, these facts are driven home, will the eyes of the public be opened; and it is surely our duty, as medical men, inculcating the great lessons of temperance, hygiene, and the laws that govern heredity, beginning with our Schools, never failing or tiring of our teaching, until we see the results in a new race, healthy in mind as well as in body.

Such results the Church, as well as our schoolmasters, might assist in bringing about, and where teaching fails, then legislation should assist the medical man in forcing people into grooves, whose ultimate goal is *mens sana in corpore sano*.